PIPS UPDATE

The Care Process Model for Pediatric Traumatic Stress (CPM-PTS)

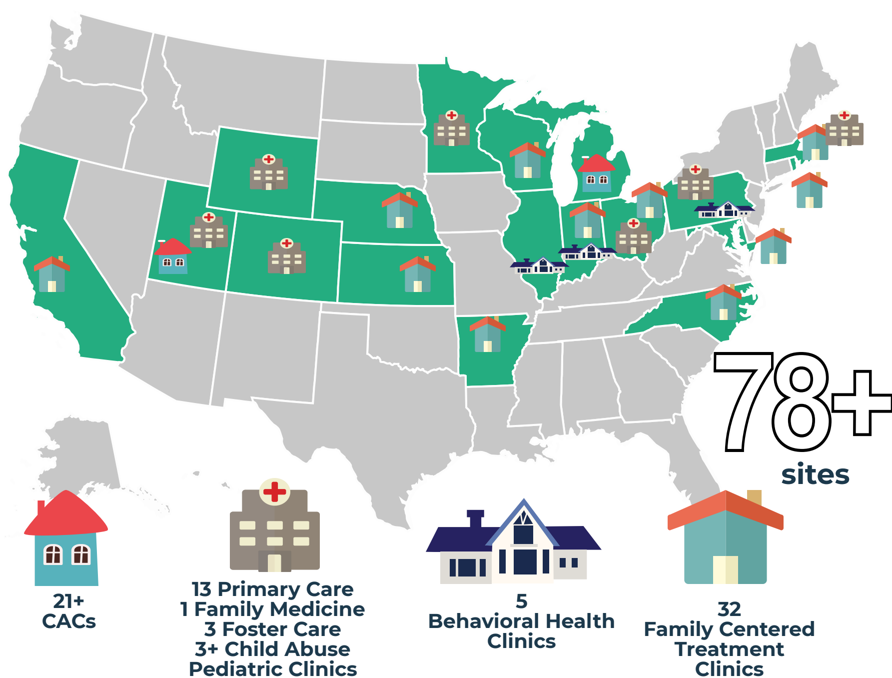
Reporting Period: July-September 2021 (FY21, Q4)

Pediatric Integrated Post-trauma Services (PIPS) is a Treatment and Service Adaptation Center (Category II) of the National Child Traumatic Stress Network (NCTSN).

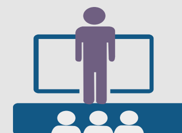
PIPS developed the Care Process Model for Pediatric Traumatic Stress (CPM-PTS) to facilitate traumatic stress screening and response for children seen in healthcare and other pediatric settings. The PIPS Update is a quarterly report and newsletter.

CPM-PTS Tracking

Map & Dashboard of Active CPM-PTS Sites



CPM-PTS Training Contacts



Quarter: 125

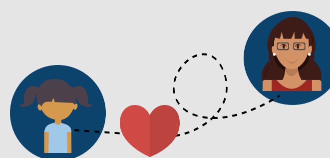
Total: 2,155+

Screening via the CPM-PTS

Quarter: 6,262+

Total: 33,598+

EBT Referral via the CPM-PTS



Quarter: 966+

Total: 3,702+

We Received Two New Funding Awards!

We received a funding award from the Cambia Health Foundation in collaboration with the National Children's Alliance (NCA) and Utah Children's Justice Center (CJC) Program to continue training and support of the CPM-PTS in rural CJCs in Utah.

We received a funding award from the Intermountain Foundation in collaboration with Primary Children's Hospital Center for Safe and Healthy Families to continue training and support of the CPM-PTS in Intermountain and community primary care clinics.

Our New Funding Awards Will Build on Work We Have Already Been Doing in Utah

28800+

Children Screened

4,950+ CJCs

23,800+ Primary Care Clinics

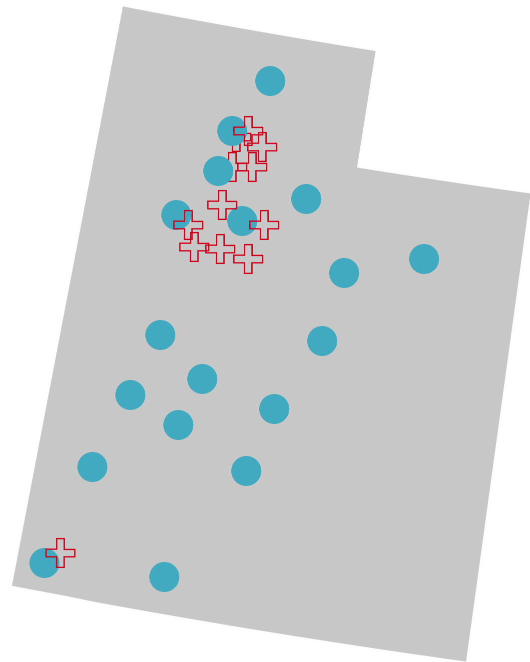
31+

Active Sites

19 CJCs

11 Primary Care Clinics

1 Child Abuse Clinic & Children's Hospital



Our Pilot Combining the CPM-PTS with SAFETY-A for Suicide Prevention in the ED was Published

EVIDENCE-BASED PRACTICE IN CHILD AND ADOLESCENT MENTAL HEALTH
2021, VOL. 6, NO. 3, 343–353
https://doi.org/10.1080/23794925.2021.1961643

Routledge
Taylor & Francis Group

Check for updates

Implementation of a Trauma-Informed Suicide Prevention Intervention for Youth Presenting to the Emergency Department in Crisis

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ABSTRACT

Given the increasing number of children presenting to the emergency department (ED) in psychiatric crisis, our tertiary children's hospital ED adopted SAFETY-Acute/Family Intervention for Suicide Prevention (SAFETY-A), an evidence-based practice for suicide prevention. Because of the relationship between trauma and suicide among youth, this study piloted the feasibility of combining SAFETY-A and a standardized approach to the detection and response to trauma in youth, the Care Process Model for Pediatric Traumatic Stress (CPM-PTS) within a busy ED setting. Over a three-month period, 30 youth with low to moderate risk for suicide received SAFETY-A+CPM in the ED. 62% of respondents reported trauma exposure, with the majority endorsing moderate or severe traumatic stress symptoms. Twenty-nine of the 30 youth were able to be safely discharged home with follow-up care. Fifteen youth were provided referrals/linkages with new providers, 5 of which were to trauma-focused assessment and treatment as indicated by the CPM-PTS. Overall, crisis workers found that offering SAFETY-A +CPM was "more rewarding" than traditional crisis evaluations and that using trauma-specific data identified with the CPM-PTS was quite helpful. Post-intervention surveys with parents indicated a favorable experience, comfort with maintaining safety, and overall satisfaction with the ED intervention. Clinical and system barriers identified over the course of the pilot are critical to address for sustained delivery. Overall, SAFETY-A was able to be delivered to fidelity and blended with the CPM-PTS.

Introduction

Suicide is the second leading cause of death for young persons, 10–24 years old, in the United States (Cha et al., 2018; Curtin & Heron, 2019) and the leading cause of death for young persons in many US states (Curtin, 2020). With age-adjusted rates of death caused by suicide increasing 24% nationally from 1999 through 2014 (Curtin et al., 2016), suicide prevention has become a top public health priority, including the development and promotion of youth suicide risk screening tools (Horowitz et al., 2009) and response protocols for high-risk populations.

Not all youth share the same level of risk, even within the same setting, and it is important for clinicians to be able to quickly differentiate risk and modify intervention strategies to target specific risk characteristics. Some youth are at greater risk for suicide based on their demographic, familial, and clinical characteristics, access to lethal means, and life experiences, including potentially traumatic events (Brezo et al., 2008; Carballo et al., 2020; Cash & Bridge, 2009; Fergusson et al., 2008; Keeshin et al., 2018; Knopov et al., 2019). History of attempted suicide is also a strong predictor of subsequent suicide attempt and death by suicide (Harris & Barraclough, 1997), and children with prior suicide attempts are an increasing percentage of those presenting to emergency departments (EDs) for crisis services (Bardach et al., 2014; Burstein et al., 2019; Kalb et al., 2019; Plemmons et al., 2018).

The response to a growing and more severely impacted population of suicidal youth presenting to emergency departments for crisis evaluations has been limited. Nationally, between 2011 and 2015, suicide-related visits among adolescents increased by 2.5 times. ED visits tended to be long (≥3 hours), and only a few youth (16%) accessed a mental health provider during their visit (Kalb et al., 2019). This means that youth with suicidality are increasingly presenting to the ED, and although the ED is a critical opportunity for suicide risk

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Because trauma and subsequent traumatic stress are potent risk factors for suicidality, we thought that the Care Process Model for Pediatric Traumatic Stress (CPM-PTS) may help identify and respond to trauma for youth presenting to the Emergency Department (ED) for crisis evaluation.

The CPM-PTS was combined with SAFETY-Acute/Family Intervention for Suicide Prevention (SAFETY-A), a trauma-informed intervention for suicide prevention, at Primary Children's Hospital ED and piloted for feasibility. Over a 3-month period, 30 youth with low to moderate risk for suicide received SAFETY-A+CPM in the ED. 62% of respondents reported trauma exposure, with the majority endorsing moderate or severe traumatic stress symptoms. Twenty-nine of the 30 youth were able to be safely discharged home with follow-up care. Fifteen youth were provided referrals/linkages with new providers, 5 of which were to trauma-focused assessment and treatment as indicated by the CPM-PTS. Overall, crisis workers found that offering SAFETY-A +CPM was "more rewarding" than traditional crisis evaluations and that using trauma-specific data identified with the CPM-PTS was quite helpful.

Click here to go to the full article, or message lindsay.shepard@hsc.utah.edu for article access.

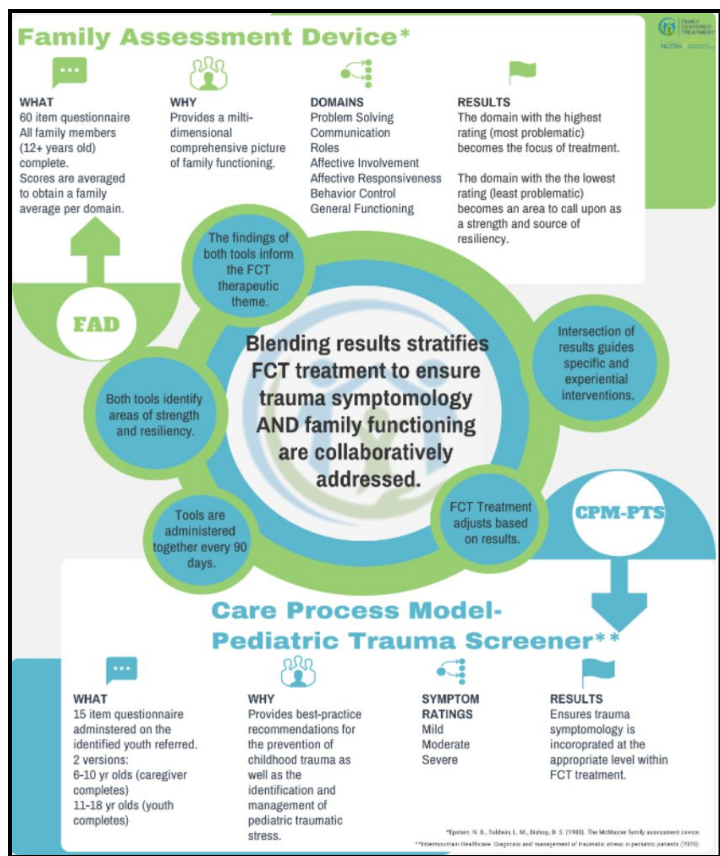
The CPM-PTS is Referenced in an AAP Clinical Report on Trauma-Informed Care

A recent clinical report of the American Academy of Pediatrics (AAP) practically addresses trauma-informed care for pediatric clinicians and references the Care Process Model for Pediatric Traumatic Stress (CPM-PTS) as a validated means of screening for pediatric traumatic stress.

Click here to go to the full article (the CPM-PTS is referenced on page 10).

PIPS Highlights & Tips

Partner Highlight:



The Family Centered Treatment Foundation (FCTF) owns an evidence-based family preservation treatment model called Family Centered Treatment (FCT), and licenses and supports its use in 32 agencies nationwide. FCTF is a Category II grantee within the National Child Traumatic Stress Network (NCTSN), which is how we came to partner.

The FCT model already had a screening tool looking specifically into how a family's dynamics impact their current levels of functioning, but according to their clinical director, Stephanie Glickman, LCSW, CCTP, "We knew we needed something more tangible and measurable to identify trauma symptomology given that most of our families are impacted by and working through their traumas. Through our partnership with NCTSN and shared participation in collaboratives, the FCT Foundation teamed up with the PIPS team after realizing they had the trauma screener we needed."

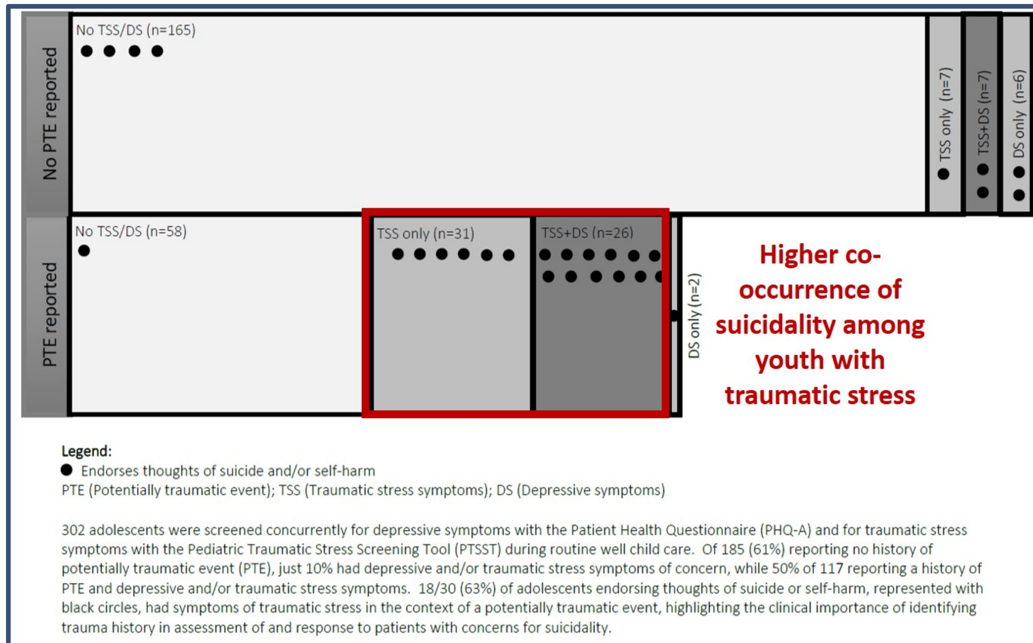
Through our recent partnership, FCTF has rolled out the CPM-PTS to their 32 agencies in 11 states, and trained over 300 providers. Since including the CPM-PTS in the FCT model, FCT Practitioners are uncovering trauma symptomology and suicidality sooner, intervening quicker, and are able to ensure more immediate supports and solutions for families. The image at left was created by FCTF to describe integration of the CPM-PTS within their model.

CPM-PTS Tip: Suicide Screening Matters

We know that asking questions and talking about suicide can bring up lots of feelings, and be scary and overwhelming. But our summary data of the CPM-PTS from both primary care and Children's Advocacy Center (CAC) settings show that suicide screening matters.

In CAC settings, 45% of adolescents, or about 1 in every 2, self-report having thought about suicide or harming themselves in some way in the last 2 weeks. 5%, or 1 in every 20, adolescents are assessed as high risk for suicide via the Columbia Suicide Severity Rating Scale (C-SSRS), meaning they indicate having suicidal intent, a plan, preparations, and/or a recent attempt.

In primary care settings among adolescents completing both the Patient Health Questionnaire for Adolescents (PHQ-A) and the Pediatric Traumatic Stress Screening Tool (PTSST), adolescents reporting potential trauma exposure (PTE) were 3.5 times more likely to report thoughts of suicide or self-harm (20/117, 17.1%) compared to those without this PTE history (9/185, 4.9%) ($p<0.001$). See chart below.



With such high co-occurrence of suicidality and traumatic stress, as well as with its potential lethality, suicide screening and response among trauma-exposed youth matters in both CAC and primary care settings!

For additional suicide prevention training, follow this link for training videos in use of the Columbia Suicide Severity Rating Scale (C-SSRS), or email lindsay.shepard@hsc.utah.edu about additional PIPS consultation.

PIPS News

Two New Babies Join the PIPS Team

This fall, our Research Staff Assistant, Porcia Vaughn, MSIS, and our Program Manager, Lindsay Shepard, PhD, LCSW, were briefly on maternity leave. Both had healthy baby boys!

Meet babies Xander and Harry, our newest PIPS team members.